

Date: \_\_\_\_\_

Name: \_\_\_\_\_

## COMBINED HORMONAL CONTRACEPTION INITIATION RECORD

Age \_\_\_\_\_

Date of Birth \_\_\_\_\_

Allergies \_\_\_\_\_

Current Method of Contraception \_\_\_\_\_

Current Medications \_\_\_\_\_

LNMP \_\_\_\_\_

Last sexual intercourse \_\_\_\_\_

### History

Current known pregnancy or suspected pregnancy ☐ yes ☐ no

Less than 21 days postpartum ☐ yes ☐ no

Currently breastfeeding ☐ yes ☐ no

Unexplained vaginal bleeding ☐ yes ☐ no

Cigarette smoker age 35 or older ☐ yes ☐ no

Headaches with focal neurological symptoms and/or aura ☐ yes ☐ no

Migraines (including without aura) if age 35 or older ☐ yes ☐ no

Known or suspected breast cancer or history thereof ☐ yes ☐ no

Hypertension (>140/90 mm Hg) or history thereof ☐ yes ☐ no

Diabetes mellitus vascular disease or >20 yrs duration, nephropathy, retinopathy, neuropathy) ☐ yes ☐ no

Current thromboembolic disease or history thereof ☐ yes ☐ no

Cerebrovascular or coronary artery disease or history thereof ☐ yes ☐ no

Hepatic disease (tumors, hepatitis, cirrhosis) ☐ yes ☐ no

Cancer of the endometrium (or estrogen dependent tumor) ☐ yes ☐ no

Heart Disease (cardiomyopathy, atherosclerotic cardiovascular disease) ☐ yes ☐ no

Lupus with positive/unknown antiphospholipid antibodies ☐ yes ☐ no

Bariatric Surgery (bypass procedure) (this is an issue for COCP only) ☐ yes ☐ no

BP \_\_\_\_\_

Urine Pregnancy Test (if indicated) ☐ pos ☐ neg

### Clinician Comments

Assessment: Combined hormonal contraception candidate? ☐ yes ☐ no

Combined oral contraceptive pill candidate? ☐ yes ☐ no

### Contraception Plan:

Combined oral contraceptive initiated? ☐ yes ☐ no

Brand name \_\_\_\_\_

Number of cycles \_\_\_\_\_

Start date \_\_\_\_\_

Other contraceptive method initiated/continued/restarted? ☐ yes ☐ no

Method name \_\_\_\_\_

### Back-up and STI Protection Plan:

Plan B ☐ offered ☐ give

Condoms ☐ offered ☐ given

Return Visit \_\_\_\_\_

Interpreter Name \_\_\_\_\_

Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

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